Remarks of
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SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
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Good Morning. This is the start of the first year of a new decade. A good time to look at what is in store for our health care system.

My own prediction is that the financing and delivery of health care are in for major changes in the 90's. I hope that the changes come sooner rather than later. But whatever the timing, they will come, because we just can't go on this way.

I don't have to tell this audience that health care costs in this country are out of control. This year we will spend $621 billion, or 10.7 percent of our GNP, on health care. If current trends continue, by the year 2000, we will be spending $1.5 trillion or 14.1 percent of GNP on health care -- without any reduction in the number of uninsured.

It just can't go on this way.

Between 31 and 37 million people in this country -- 13 to 18 percent of the nonaged population -- are uninsured. Of those, 80 percent are workers or their families.

Let me say that again: In our job-based health care system, 25 to 28 million gainfully employed Americans and their spouses and their children have no health care coverage whatsoever.

Or look at it another way. Between 8 and 10 million children -- 13 to 16 percent of all kids -- are uninsured. No private coverage. No Medicaid. These are the kids who will be the work force when I and most of you are on Social Security. We are making no investment in their health. Among our international competitors, only South Africa is so stupid.

It just can't go on this way.

Then there is AIDS. People have a tendency to forget this, but we find ourselves in the midst of the worst epidemic in modern history. There are at least a million Americans infected, and over 60,000 have already died. Both because private insurers are screening these people out and because the disease disables people so quickly, Medicaid is becoming the predominant payor for AIDS care. And while Medicaid pays for the inpatient care of people who get acutely ill with AIDS, it won't pay for the preventive care to keep infected people from getting acutely ill.

It just can't go on this way.

As you in business know better than I, the small business insurance market is collapsing. It seems that rather than spreading the risk,

insurers in the market are doing all they can to avoid it through medical underwriting and similar risk-selection techniques.

Three months ago, my Subcommittee held a hearing on this issue. We heard from Karen Allen, a 47-year-old worker in a 2-person floor covering firm in a Maryland suburb. The firm paid coverage for Ms. Allen, her daughter, and the other employee, at a total cost of $325 per month, effective November 1st, 1987. The next year the premiums were raised 23 percent to $401 per month, and the firm was notified that all preexisting conditions for new employees and dependents would be excluded. During that year, Ms. Allen had surgery for an herniated disc at G.W. University Hospital. The insurer promptly notified the company that its 1989 rates would be increased to a total of $743 -- an increase of 130 percent in just 2 years.

Ms. Allen's weekly salary is $250. After taxes, her health insurance premiums represent 50 percent of her total take home pay. What are her options? She could lower that premium by switching to a policy with a $1000 deductible -- or a month's gross salary. That will teach her to get sick.

And let's remember. She is lucky. Her employer actually offers coverage, at least for now. And he hasn't fired her.

Lorraine Colletti's dad didn't fare so well. Lorraine is a 13-year old who is fighting a cancerous brain tumor. The St. Petersburg Times reports that her father was recently fired from his job at a small Tampa

company, which said that his work was unacceptable. It is remarkable, though, that the firing of this 8-year employee came 3 days before the company had to make a special premium payment for him of $2,774.

Finally, as the New York Times recently reminded us, many insurers are blacklisting certain types of small businesses and professions. And it's not just those lines of business in which employees are perceived by insurers to be at greater risk of AIDS, such as entertainment and arts groups and beauty salons. It's also a lot of stores on the main street of our economy's service sector: hotels, motels, restaurants, car washes, laundries, cleaners, bowling alleys, lumberyards, pest control services, service stations, convenience stores, farms, golf clubs, ski resorts, and -- of all things -- camps.

Clearly, the system is not working for small businesses. They do not have the option to self-insure as an individual business. And, if they are in a blacklisted line of work, they won't find any private insurance at any cost. And even those who aren't blacklisted may be denied coverage entirely if any employees or dependents have been sick or are high-risk.

Or, if they can find a plan, their premium rates skyrocket after the first illness, and people are arbitrarily dropped in the time of real need. Small businesses simply cannot buy a good health insurance plan at a fair price and have any confidence that it will still be in force when it's needed.

It just can't go on this way.

We've spent the last ten years waiting for the invisible hand of the marketplace to solve these problems by itself. But things have only gotten worse. Government is going to have to play a major role. Just what that role should be is the basic question facing the U.S. Bipartisan Commission on Comprehensive Health Care. The charge of the Pepper Commission is to report, by March 1st, on recommendations for policies that will assure all Americans access to basic health care coverage and access to coverage that provides them necessary long-term care and financial protection.

No problem.

The Commission is composed of 6 Members of the Senate, 6 Members of the House, Democrats and Republicans, and 3 Presidential appointees. Their views run the spectrum from advocates of comprehensive national health insurance to advocates of a system of tax-driven market incentives. As one of the Members, I can tell you that Chairman Rockefeller is absolutely committed to developing a workable and politically viable set of recommendations that have a chance of enactment. I think he will succeed.

I don't know at this point precisely where the Commission will come out. But I'd like to share with you some of my thoughts on how we create a health care system that can go on -- that can improve the health status of our people without bankrupting us all.

I would begin by building on the existing job-based system of health care coverage. If we were starting from scratch, I might not want to tie

health care coverage to employment. But we're not starting from scratch. Most of those who have insurance coverage in this country have it through their workplace. In my judgment, the only realistic course is to start where we are and improve upon it.

My improvements would be along the following lines. First, I'd require all employers, large and small, either to offer their employees and dependents a basic set of benefits, or to contribute a percentage of their payroll toward a public plan. Thus, health care coverage would become a cost of business for all employers; no employer could undercut the competition by denying coverage to its workers and their families.

As the small businesses will be the first to point out, this approach waddles and quacks like a tax. But we are not going to fix our health care system unless everyone pulls his oar. And that includes employers. Without employer participation, the only alternative is a massive public plan, the costs of which would be prohibitive.

Now it would be completely unreasonable to require employers to offer coverage without making some major changes in the marketplace in which they have to purchase that coverage.

-- Employers need access to basic coverage at an affordable price. This means requiring insurers to offer basic policies without medical underwriting and without experience rating.

-- They need some way to limit provider price increases. This means giving the purchasers of health care the leverage to

negotiate effectively with hospitals and physicians.

-- They need protection against mandates of additional benefits imposed by States. This means preempting State minimum benefits laws with a uniform Federal basic benefit requirement.

Now there are a fair number of people who would not be reached by the employer-based system -- part-time workers, the unemployed, and the poor. For these people, and for the workers of those employers who elect to pay the contribution rather than offer coverage, I would establish a new public plan.

Specifically, I would replace the Medicaid program with a Federally financed, Federally administered entitlement program offering a uniform basic benefit package throughout the country. This new program would not be only for the poor. It would be completely divorced from the welfare system, and private employers would be able to buy their employees into it if they chose to do so. It would pay providers far more reasonable compensation for their services than many State programs now do.

Any program we enact will have to include cost controls. What we've got now is a game in which each payor looks out for itself, and costs get shifted, not contained. That can't continue, particularly if we are going to put large amounts of additional Federal and employer dollars into the system to pay for the uninsured.

Even with effective cost controls, this new public program will cost money. Depending on how it is structured, and on how many employers opt not to offer their employees private coverage, the costs could range from about $28 billion to $45 billion per year. That's roughly equal to a 15 percent reduction in our current defense budget.

Whatever the size of the peace deficit, it is not a stable source of financing for a program of this size. New taxes will be necessary. I would favor using a progressive, broad-based income tax surcharge paid by everyone. We're all in this together.

My approach assumes a major role for both private insurers and self-insurers. Employers could continue to self-insure, and could continue to offer broader benefits than just the basic package. Private insurers could continue to offer health insurance products other than basic policies. In addition, they could help administer the new public plan on a contract basis, much as Medicare carriers and intermediaries now do. But the rules would be changed with respect to basic health care policies. Medical underwriting would be prohibited, and community rating would be required.

Whatever recommendations the Pepper Commission makes, it is unlikely all of them will be enacted this year. The Congress and the American people will need some time to debate and discuss them, and the Administration is likely to urge that we wait until its two study groups complete their work. The Governors have already asked that we

wait until they develop their own recommendations, in the spring of 1991.

I do not intend to wait. The Pepper Commission report will lay out all the options and all the facts. We have to start making some decisions.

While we move forward on broad reform, the Congress will continue the step-by-step process of considering and passing individual health initiatives.

Last year we made some progress in expanding the Medicaid program to more low-income pregnant women and young children. That will mean over 800,000 fewer people without health care coverage.

But that leaves well over 30 million uninsured. Obviously, we need to do more.

During the campaign, Candidate Bush promised to extend Medicaid coverage to all pregnant women and infants will incomes below 185 percent of the poverty level. He also promised to extend coverage to all poor children. I want to help him honor his commitment.

We also need to do more to provide long-term care services in the home and community for the frail elderly and for people with mental

disabilities. No one should be forced into nursing homes or institutions because they lack access to services where they live. Proposals to eliminate the institutional bias in the Medicaid program passed the House last year, and I am hopeful that this year they will see enactment.

And we need to do more to provide preventive services to people who are infected with HIV. No one should be forced to get AIDS simply because they can't afford the drugs to prevent it.

The broad-gauged reforms that are needed in our health care system ill not come easily. The Federal deficit, the Administration's adamant opposition to making sensible investments in domestic needs, and opposition to effective cost controls will make reform a very difficult undertaking. But I'm confident that reform will come.

Because it just can't go on this way.